New Jersey Department of Health and Senior Services
Clinical Laboratory Improvement Services
PO Box 361
Trenton, NJ 08625-0361

BLOOD BANK ANNUAL STATISTICS
(Out of Hospital Transfusion Services)

Name of Blood Bank	County
Address	
Name of Individual Completing Form	Telephone Number

Please furnish the following data for the report year and return to the above address, by the due date given on the attached cover letter. Please retain the canary copy for your files. If assistance is needed, contact the Clinical Laboratory Improvement Service at 609-292-0522.

A. SOURCES OF SUPPLY	**Whole Blood**	**Packed Cells ***	**Totals**
1. Number of units supplied directly by:			
a. Bergen Community Regional Blood Center			
b. Community Blood Council of New Jersey			
c. Central Jersey Blood Center			
d. Blood Center of New Jersey			
e. New Brunswick Affiliated Hospital Blood Program			
f. American Red Cross			
1. Greater N.Y. Blood Program			
2. New Jersey Blood Services			
3. Penn-Jersey, New Jersey Locations			
4. Penn-Jersey, Philadelphia			
5. Other Red Cross			
g. Out-of-State Community (Name and State) 1.			
2.			

*Include frozen, washed and leukocyte-poor red cells in this total (refer to Page 3, Section D, Number 4, 5 and 6).

A. SOURCES OF SUPPLY, Continued	**Whole Blood**	**Packed Cells ***	**Totals**
h. Commercial Blood Banks (Name and State) 1.			
2.			
i. Blood Received Directly from AABB Exchange Programs (actual units, not credits): 1. Volunteer Sources			
2. Commercial Sources			
j. Directly from Other Hospitals			
TOTAL SUPPLY			

B. UNITS RETURNED (Only Unexpired Whole Blood or Packed Cells)	**Totals**
1. To County or Community Blood Banks	
2. To Red Cross Centers	
3. To Commercial Suppliers	
4. Sent to Other Hospitals: a. Through the American Assoc. of Blood Banks (actual units, not credits)	
b. By directed transfer	
5. Balance on hand December 31 of year prior to the report year	
TOTAL	

C. USAGE (Whole Blood and Packed Cells)	**Whole Blood**	**Packed Cells**	**Totals**
1. Number of units (count split units as one) a. Transfused as Routine			/ / / / / / / / / / / / /
b. Transfused as Autologous			/ / / / / / / / / / / / /
c. Transfused as Directed			/ / / / / / / / / / / / /
Total Transfused			
2. Number of individual patients transfused			
3. Number of units discarded			

a. Reasons (Specify):

1. _____
2. _____
3. _____
4. _____
5. _____

BLOOD BANK ANNUAL STATISTICS, Continued

C. USAGE (Continued)	Totals
4. Number of Transfusion Reactions a. Febrile (Nonhemolytic)	
b. Allergic	
c. Hemolytic (Cause)	
1. ABO (Specify)	
2. Clerical (Specify)	
3. Technical (Specify)	
4. Other (Specify)	
d. Anaphylaxic	
e. Delayed	
1. Number of Days After Transfusion	
2. Antibody or Cause of Reaction	
f. Hepatitis-Related	
TOTAL	

D. BLOOD COMPONENTS	Number of Units				
	Received From			Transfused by Your Bank	Outdate
	Name	State	Number		
1. Fresh frozen plasma					
2. Platelet concentrates					
3. Cryoprecipitates					
4. Frozen red cells**					
5. Washed red cells**					
6. Leukocyte-poor red cells**					
7. Leukocytes					
8. Rh (D) Immune Globulin					
a. Blood Bank					
b. Pharmacy					
9. Other (Specify):					

**Include in Packed Cells under A (Page 1) and C1 (Page 2).

Signature of Blood Bank Director	Date